

### **SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 3**

This exhibit is intended to provide disclosure of expenses by major type of activity that improves health care quality, as defined below, as well as the amount of those expenses that is used for other activities, and reported separately for the comprehensive health coverage (individual, small group and large group business), mini-med plans (individual, small group and large group business) and expatriate plans.

This exhibit also shows the amount of qualifying HIT expenses, reported separately for the comprehensive health coverage (individual, small group and large group business), mini-med plans (individual, small group and large group business) and expatriate plans, broken down into the four categories of Quality Improvement expenses (see below); similarly, the Other than HIT qualifying Quality Improvement expenses are disclosed for each of the four categories of Quality Improvement expenses.

The definitions of Individual, Small Group and Large Group are found in the instructions for Parts 1 and 2 of this supplement exhibit.

#### **Improving Health Care Quality Expenses – General Definition:**

Quality Improvement (QI) expenses are expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs), for all plan activities that are designed to improve health care quality and increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.

The expenses must be directed toward individual enrollees or may be incurred for the benefit of specified segments of enrollees, recognizing that such activities may provide health improvements to the population beyond those enrolled in coverage, as long as no additional costs are incurred due to the non-enrollees other than allowable QI expenses associated with self-insured plans.

Qualifying QI expenses should be grounded in evidence-based medicine, widely accepted best clinical practice or criteria issued by recognized professional medical societies, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

They should not be designed primarily to control or contain cost, although they may have cost-reducing or cost-neutral benefits, as long as the primary focus is to improve quality.

Qualifying QI activities are primarily designed to achieve the following goals set out in Section 2717 of the PHSA and Section 1311 of the PPACA:

- Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reducing health disparities among specified populations;
- Prevent hospital readmissions;
- Improve patient safety and reduce medical errors, lower infection and mortality rates;
- Increase wellness and promote health activities; or
- Enhance the use of health care data to improve quality, transparency and outcomes.

NOTE: Expenses that otherwise meet the definitions for QI but were paid for with grant money or other funding separate from premium revenues shall NOT be included in QI expenses.

Column 1 – Improve Health Outcomes

Expenses for the direct interaction of the insurer (including those services delegated by contract for which the insurer retains ultimate responsibility under the insurance policy), providers and the enrollee or the enrollee's representatives (e.g., face-to-face, telephonic, Web-based interactions or other means of communication) to improve health outcomes as defined above.

This category can include costs for associated activities such as:

- Effective case management, care coordination and chronic disease management, including:
  - Patient-centered intervention, such as;
    - Making/verifying appointments,
    - Medication and care compliance initiatives;
    - Arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center);
    - Programs to support shared decision-making with patients, their families and the patient's representatives; and
    - Reminding insured of physician appointment, lab tests or other appropriate contact with specific providers;
  - Incorporating feedback from the insured to effectively monitor compliance;
  - Providing coaching or other support to encourage compliance with evidence-based medicine;
  - Activities to identify and encourage evidence-based medicine;
  - Use of the medical homes model as defined for purposes of Section 3602 of PPACA;
  - Activities to prevent avoidable hospital admissions;
  - Education and participation in self-management programs; and
  - Medication and care compliance initiatives, such as checking that the insured is following a medically effective prescribed regimen for dealing with the specific disease/condition and incorporating feedback from the insured in the management program to effectively monitor compliance;
- Accreditation fees by a nationally recognized accrediting entity directly related to quality of care activities included in Columns 1 through 5;
- Expenses associated with identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence-based medicine;
- Quality reporting and documentation of care in non-electronic format; and
- Health information technology expenses to support these activities (report in Column 5 – see instructions) including:
  - Data extraction, analysis and transmission in support of the activities described above; and
  - Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient's care.

Column 2 – Activities to Prevent Hospital Readmission

Expenses for implementing activities to prevent hospital readmissions as defined above, including:

- Comprehensive discharge planning (e.g., arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help ensure appropriate care that will, in all likelihood, avoid readmission to the hospital;
- Personalized post-discharge counseling by an appropriate health care professional;
- Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission; and
- Health information technology expenses to support these activities (report in Column 5 – see instructions) including:
  - Data extraction, analysis and transmission in support of the activities described above; and
  - Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient's care.

Column 3 – Improve Patient Safety and Reduce Medical Errors

Expenses for implementing activities to improve patient safety and reduce medical errors (as defined above) through:

- The appropriate identification and use of best clinical practices to avoid harm;
- Activities to identify and encourage-evidence based medicine in addressing independently identified and documented clinical errors or safety concerns;
- Activities to lower risk of facility acquired infections;
- Prospective prescription drug utilization review aimed at identifying potential adverse drug interactions;
- Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors; and
- Health information technology expenses to support these activities (report in Column 5 – see instructions), including:
  - Data extraction, analysis and transmission in support of the activities described above; and
  - Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient's care.

Column 4 – Wellness & Health Promotion Activities

Expenses for programs that provide wellness and health promotion activity as defined above (e.g., face-to-face, telephonic or Web-based interactions or other forms of communication), including:

- Wellness assessment;

- Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;
- Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition; and
- Public health education campaigns that are performed in conjunction with state or local health departments.

- Actual rewards/incentives/bonuses/reductions in co-pays, etc. (not administration of these programs) that are not already reflected in premiums or claims should be allowed as QI with the following restrictions:
  - Only allowed for small and large employer groups, not individual business; and the expense amount is limited to the same percentage as the HIPAA incentive amount limit;
- Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;
- Coaching or education programs and health promotion activities designed to change member behavior (e.g., smoking, obesity); and
- Health information technology expenses to support these activities (Report in Column 5 – See instructions).

Column 5 – HIT Expenses for Health Care Quality Improvements

The PPACA also contemplates “Health Information Technology” as a function that may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current QI or make new QI initiatives possible. Include HIT expenses required to accomplish the activities reported in Columns 1 through 4 that are designed for use by health plans, health care providers or enrollees for the electronic creation, maintenance, access or exchange of health information, consistent with Medicare/Medicaid meaningful use requirements, in the following ways:

1. Monitoring, measuring or reporting clinical effectiveness, including reporting and analysis costs related to maintaining accreditation by nationally recognized accrediting organizations, such as NCQA or URAC; or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (e.g., CAHPS surveys or chart review of HEDIS measures) and costs for public reporting mandated or encouraged by law;
2. Advancing the ability of enrollees, providers, insurers or other systems to communicate patient-centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care – this may include electronic health records accessible by enrollees and appropriate providers to monitor and document an individual patient’s medical history;
3. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;
4. Reformatting, transmitting or reporting data to national or international government-based health organizations for the purposes of indentifying or treating specific conditions or controlling the spread of disease; or
5. Provision of electronic health records and patient portals.

Exclude: Costs associated with establishing or maintaining a claims adjudication system, including costs directly related to upgrades in HIT that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims (e.g., costs of implementing new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended, including the new ICD-10 requirements.

NOTE:

- a. Healthcare Professional Hotlines: Expenses for healthcare professional hotlines should be included in Claims Adjustment Expenses to the extent they do not meet the criteria for the above defined columns of Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, and Wellness & Health Promotion Activities.
- b. Prospective Utilization Review: Expenses for prospective utilization review should be included in Claims Adjustment Expenses to the extent they do not meet the criteria for the above defined columns of Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, and Wellness & Health Promotion Activities, AND the prospective utilization review activities are not conducted in accordance with a program that has been accredited by a recognized accreditation body.

The following items are broadly excluded as not meeting the definitions above:

- All retrospective and concurrent utilization review;
- Fraud prevention activities (all are reported as cost containment, but Part 1, Line 4 includes MLR recognition of fraud detection/recovery expenses up to the amount recovered that reduces incurred claims);
- The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network;
- Provider credentialing;
- Marketing expenses;
- Any accreditation fees that are not directly related to activities included in Columns 1 through 5;
- Costs associated with calculating and administering individual enrollee or employee incentives; and
- Any function or activity not expressly included in Columns 1 through 5.

NOTE:

The NAIC will review requests to include expenses for broadly excluded activities and activities not described under Columns 1 through 5 above. Upon an adequate showing that the activity's costs support the definitions and purposes therein, or otherwise support monitoring, measuring, or reporting health care quality improvement, the NAIC may recommend that the HHS Secretary certify those expenses as Quality Improvement.

The sections for comprehensive health coverage (individual, small group and large group business), mini-med plans (individual, small group and large group business) and expatriate plans are defined as per the comprehensive health coverage (individual, small group and large group business), mini-med plans (individual, small group and large group business) and expatriate plans columns in Parts 1 and 2 of this supplement.

For questions on definitions, refer to the instructions for the Annual Statement Expenses Schedule (i.e., the Underwriting and Investment Exhibit, Part 3 for P/C and Health, and Exhibit 2 for Life and Fraternal), for the line references provided below. **DIFFERENT FROM A/S EXPENSE REPORTING:** For non-affiliated management agreements/outsourced services, report all amounts in the supplement's Line 1.2, 2.2, 3.2, 4.2, 5.2, 6.2 or 7.2 for Outsourced Services (not just those amounts less than 10% of total expenses). Continue to allocate all affiliated management agreements/outsourced services to the appropriate expense lines as if the costs had been borne directly by the insurer.